Child and Adolescent Psychiatry

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Child and Adolescent Psychiatry Fellow

Learning Objectives

- To learn how child/adolescent psychiatry differs from adult psychiatry
- To develop a basic understanding of psychiatric disorders usually first diagnosed in infancy, childhood, or adolescence
- To become acquainted with child/adolescent psychiatry treatment issues

Differences from Adult Psychiatry

- Developmental issues
- Different assessment process
  - Who requested the assessment; how evaluation is conducted
- Different diagnoses
- Treatment differences

Presentation of Disorders

- Pre-school
  - ADHD
  - ODD
  - Developmental Disorders
  - MR

Presentation of Disorders

- School Aged
  - Depression
  - Anxiety
  - Learning Disorders
  - Tic Disorders
  - ADHD/ODD

Presentation of Disorders

- Adolescents
  - Conduct Disorder
  - Substance Use Disorders
  - Mood Disorders: Depression, Bipolar Disorder
  - ADHD, ODD

Mental Retardation

- IQ < 70 AND impairment in adaptive functioning in 2 areas; onset before 18 yo.
- Mild, Moderate, Severe; mild most common
- Seizures are common
- Increased risk of psychopathology
- Causes- chromosomal, metabolic, psychosocial deprivation

MR: Treatment

- Socialization- play and coping skills
- Vocational training; Daily Living Skills
- Medication as needed- increased risk for epilepsy; cardiac problems and Alzheimer’s in adults with Down’s.
- Case coordination is key.

Learning Disorders

- Deficits in reading, writing, or math
- 10-15% of school aged children, boys>girls
- Diagnose when achievement is >2 SD below level predicted from intelligence
- Interferes with academic achievement
- Learning DO NOS- problems in all three areas; together interfere with achievement

Developmental Disorders

- Developmental Coordination Disorder- deficits in performing motor skills; interferes with ADLs and academic achievement.
- Expressive Language D/O- impaired production and communicative use of language
- Mixed Receptive-Expressive Language D/O- impaired comprehension and expression.

Developmental Disorders

- Phonological DO- failure to use age appropriate speech sounds
- Stuttering- disturbance in normal fluency and time patterning of speech
- Communication DO NOS- disorder in voice quality, tone, pitch, loudness; not meeting criteria for specific Communication DO.

Other Pervasive Developmental Disorders

- Childhood Disintegrative Disorder
  - 2 yrs nl development followed by loss of acquired skills in 2 areas (play, motor, social, expressive/receptive, bowel/bladder) before 10.
- Rett's Disorder
  - X-linked, only seen in females, loss of purposeful hand movements, head growth deceleration between 5 and 48 months

Autism

- Law of 3's:
  - onset prior to age 3
  - severe impairment in social interaction (2 minimum), Communication (1 minimum), behavior/interests (1 minimum)
- Prevalence 7.2/10,000 (Fombonne, 1999)
- 50% have IQ >70 (Honda 1996)
- Social features (language skills and nonverbal intelligence) best predicts independence.

Asperger's Disorder

- Similar to Autism with impaired social interaction but language and cognition are generally preserved
- Children often have one narrow area of interest; also with repetitive or stereotyped behavior and activities.
- Odd prosody of speech
- Motor clumsiness

Attention Deficit and Disruptive Behavior Disorders

- ADHD- combined; predominantly inattentive; predominantly hyperactive- impulsive
- Conduct Disorder- childhood onset, adolescent onset, unspecified onset
- Oppositional Defiant Disorder
- Disruptive Behavior Disorder NOS

ADHD

- Either 6 symptoms of inattention or 6 symptoms of hyperactivity/impulsivity
- Symptoms begin before age 7
- Symptoms > 6 months and functionally impairing in > 2 settings (school, home)
- Prevalence rate of at least 5%
- Boys > Girls, 4:1 – 9:1(community vs clinical)

ADHD

- Co-morbidity very common
  - ODD
  - Learning and Communication D/O common
  - Conduct Disorder in 50%
  - ADHD occurs in 25% of boys w/Tourette's
  - Bipolar disorder-about 20% of ADHD kids
  - Depression and Anxiety

ADHD

- Pathophysiology
  - Dopamine, Serotonin, Glutamate, GABA in the prefrontal cortex and caudate
  - EEG abnl in 20% (vs 15% in normals)
  - Cerebral hypoperfusion in frontal lobes
  - Deficits in response inhibition on neuropsych testing

Treatment of ADHD

- Medications
  - Stimulants work in 75%
  - Alpha agonists, buproprion, atomoxetine, TCA
- Environmental interventions
  - Reduce overstimulation, provide sense of control
- Special education assistance
- Parent management training
- Social skills group

Conduct Disorder

- Repeated violation of societal norms or the rights of others
- 3 of 15 symptoms in the past year, such as aggression to people/animals, property destruction, theft, serious rule violations before age 13
- Functional impairment
- Childhood onset CD is before age 10

Conduct Disorder

- Seen in 50% of convicted juvenile delinquents
- Among the most severe behavior d/o in children
- PTSD, dissociative d/o, learning, mood, substance use d/o co-morbid

Conduct Disorder Etiology

- Super-ego lacunae
- Social deprivation
- Substance use
- FH of antisocial PD, mood, Substance abuse, and disruptive behavior d/o's
- Neurological factors
  - Physical abuse, head injury, perinatal problems, exposure

Conduct Disorder Treatment

- Contain behaviors
- Set limits
- Cognitive Behavioral Therapy to problem solve
- Empathy training
- medication

Oppositional Defiant Disorder

- A pattern of negative, hostile, defiant behavior for 6 months; usually against an authority figure.
- 4 of 8 symptoms such as losing temper, arguing, spiteful behavior, deliberate annoying
- Functional impairment
- Criteria not met for conduct disorder

Oppositional Defiant Disorder

- Oppositionality is normal from age 18-36 months and in adolescence
- Prevalence of 6%
- Winning the struggle is goal for the child
- Some will progress to Conduct d/o
- Tx = behavioral interventions

Feeding and Eating Disorders

- Pica- eating non-nutritive substances for at least 1 month; not cultural practice
- Rumination Disorder- repeated regurgitation and rechewing of food for 1 mo after normal functioning; r/o GERD
- Feeding D/O of infancy or early childhood- failure to eat enough to gain wt or significant wt loss over 1 month; r/o medical conditions; onset <6 yo.

Tic Disorders

- Tourette's Disorder
- Chronic Motor or Vocal Tic
- Transient Tic Disorder- >1 month but <1 year; onset before age 18
- Tic Disorder NOS

Tic- sudden, rapid, recurrent stereotyped movement or vocalization

Tourette's Disorder

- Multiple motor and >1 vocal tic occurring many times/day for >1 yr.
- Waxes and wanes but never a symptom- free period >3 months
- Prevalence of 1 in 1500
- Male:female of 3:1
- Tx= neuroleptics, Clonidine

Elimination Disorders

- Enuresis- repeated voiding of urine into bed or clothes twice/week for 3 months after age 5.
- Encopresis- repeated voluntary or involuntary fecal soiling once a month for 3 months after age 4.
  - Most commonly caused by chronic constipation w/overflow incontinence

Other Disorders of Infancy, Childhood and Adolescence

- Separation Anxiety Disorder
- Selective Mutism
- Reactive Attachment Disorder of Infancy or Early Childhood

Separation Anxiety Disorder

- Developmentally inappropriate and excessive anxiety concerning separation from home or attachment figures
- Anxiety or mood d/o usually co-morbid
- High rate of school absences
- Tx= individual and family therapy, SSRI or TCA

Selective Mutism

- Consistent failure to speak in specific situations despite speaking in other situations
- Occurs for at least 1 month and interferes w/achievement or social communication
- Symptoms start between ages 3-5
- Tx= Fluoxetine, behavior therapy, speech therapy, if indicated

Child Abuse

- Increased in premature babies, families w/substance abuse, and multiple psychosocial stressors
- Physical-parental hx may not match injuries, guarded attitude, frequent ER visits
- Sexual-any sexual contact, prostitution, or pornography

Biological Treatments

- Informed consent should include lack of FDA approval for most psychotropics
- Psychopharmacology should never be the sole treatment with children

Psychological Treatments

- Consider psychological testing and/or educational testing
- Therapy might include play therapy, group therapy, and family therapy

Social Treatments

- Consider parental guidance, school interventions, tutoring, sports involvement, mentoring

Questions?